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A Clinical Lecture delivered at the Philadelphia Hospital, November 9, 1892.

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GENTLEMEN: This woman who enters the clinic room with her baby in her arms, walks, you see, with as firm and confident a step as yours or mine. She was delivered five weeks ago by pubeotomy, after a labor that had lasted forty-eight hours without the engagement of the head in the superior strait. In less than an hour after the operation began, the child was born alive and well. It has, as you see, thriven since. The mother's convalescence was complicated by a phlegmasia that appeared on the twelfth day, but has now subsided. This, I think, was due to the long pressure by the head upon the superior strait and the consequent compression of the bloodvessels in that situation. It is not my purpose to describe at length the history, recent and remote, of the operation, or its technique.[1] This I shall reserve for another time. Suffice it to say that the latter is easy and simple. The operation can be performed

[1] A description of both may be found in THE MEDICAL NEWS of October 15, 1892.

by anyone who has a little experience in surgery, and has learned the principles of asepsis. Indeed, I fear that the symphysis pubis will be opened unnecessarily many a time in the future, and while the great present interest in the operation continues, I dare say we shall hear of women thus delivered who have had several children before without assistance. One of the most pleasant features of the renaissance of pubeotomy is the blow it deals craniotomy upon the living child. Up to the present time we have been obliged, at term, to offer to the parents the choice of Cesarean section and craniotomy in cases of contracted pelves in which forceps or version was out of the question. In my experience—a large one in such cases—Cesarean section has been refused without exception, when the true comparison of risks was stated. In the future, with an operation at my command, safer, easier, and usually quicker than craniotomy, I shall never again, I believe, do craniotomy upon a living child. The field of Cesarean section must also be very greatly limited by our knowledge of pubeotomy. For the relative indication, at least, it will be displaced entirely.

Our next patient, who is now brought in on a stretcher, gave me yesterday a most peculiar history. She was delivered by forceps four weeks ago, of a dead infant, after a labor of fourteen hours. She has had a number of children before and all of her previous labors were remarkably short and easy. A day or two after the baby's birth, she noticed water escaping from the vagina, so that she was constantly kept wet. When she got out of bed and walked about, the flow became intermittent, gushing out at frequent intervals and in large quantities. Yesterday, as she walked across the ward, there was a sudden escape of water, making quite a pool on the floor, so that one of the other patients called to the nurse that the bag of waters had ruptured. On hearing this history I thought, of course, of a vesico-vaginal

fistula, but the woman assured me that the water never had the odor of urine, which was passed naturally, and this statement was confirmed by the head nurse. Nevertheless, I still suspected the presence of a fistula, but on a superficial examination I failed to find it. I shall now repeat my examination before you, and by care and persistence I trust we shall discover the source of this peculiar discharge. I first make a digital examination of the vagina. I find no trace of a fistula on the anterior wall; there is, however, the cicatrix of an extensive tear in the anterior and left lateral vaginal vault, that I shall test in a moment with the sound. The cervix is not much injured; the womb is in good position, well forward, of normal size, and movable.

I now pass a sound into the bladder, and sweep its tip carefully and slowly over the posterior wall and fundus, looking for an unnatural opening. As I reach the area corresponding with the cicatrix in the vagina, I am doubly careful and follow the point of the sound in the bladder with my finger in the vagina. I discover, however, nothing like an opening. While thus engaged I notice some clear fluid trickling out of the vulva; I smell it on my fingers, but cannot detect a urinous odor. I shall now sound the uterus. I pass the uterine sound repeatedly through a cake of soap until I am sure that it is clean. In my office I should use a 50 per cent. solution of carbolic acid in glycerin. It is a matter of conscience with me to see that this instrument is clean before I employ it, which is not often. Having curved the end quite sharply, I slowly and gently pass the sound into the cervix and then forward into the uterine cavity. It enters two and a half inches. I notice, however, a rough surface near the internal os posteriorly, that needs investigation. I withdraw the sound, cleanse it again, straighten out the tip, and passing it through the cervical canal direct it posteriorly, using no force. It passes through an opening and glides upward to a dis-

tance of four inches from the external os. At the same time there is a gush of this clear fluid. We have solved the mystery. This woman's uterus was ruptured in her last labor. The accident escaped the notice of the attending physician. The pelvic peritoneal cavity posteriorly was quickly shut off from the region above by adhesions. An encysted peritonitis or ascites developed, and hence the discharge. This condition after labor is not unheard of, but it is extremely rare. I shall trust to time to obliterate the cavity and close the opening in the womb. A more active treatment is uncalled for, as the woman has no fever and suffers no pain.[1]

The next patient is also a puerpera. Her baby was born ten days ago. Ever since, she has complained of pain in the right leg. On examination there is excessive tenderness along the course of the sciatic nerve in the thigh, and in the leg down the central part of the calf, and along the outer edge of the tibia in front. When the woman attempted to step from her bed to the stretcher she suffered acutely, and found that the usefulness of the right leg was impaired. You are prepared, of course, to hear the diagnosis: Neuritis from pressure upon the lumbo-sacral plexus in labor. This is a rather rare condition. But when one studies the anatomic disposition of these nerve-trunks in the pelvis, and sees at least the possibility of injurious pressure upon them in prolonged labors; when one knows, besides, that they may be pressed upon by an exudate after labor, or may be actually involved in a septic inflammation, the only wonder is that neuritis as a consequence of parturition is not more frequently seen.

I now make a vaginal examination, directing my attention to the large pelvic nerve-trunks, and I find at the region of the greater sciatic foramen some swelling and exquisite sensitiveness. You see the woman flinch

[1] The woman is now well. There has been no discharge for several days.

and hear her cry out as I merely touch this point. I have so disturbed her that I really cannot judge whether there is increased sensitiveness as I attempt to follow the course of the lumbo-sacral plexus upward, but the pain is great, I am sure.

One usually expects a history of prolonged labor or unusual presentation and position of the child in a case of this sort, but our patient tells us that her labor lasted but half an hour. Her intelligence is not great, however, and I think she is mistaken, for I find, as I measure her with a pelvimeter, a simple flat pelvis, with an external conjugate of only 17 cm. It is possible, I admit, that damage may be inflicted upon the lumbo-sacral plexus in a very rapid labor. It has followed the rapid extraction of the head in breech-presentations; but this is rare.

Time may do much or perhaps all to relieve this woman. But I shall seek advice as to her treatment from my colleague, Dr. Charles K. Mills, who has taken a special interest in the subject, and has reported several cases of the kind at a later period, when there was paralysis and wasting of the muscles.

The next patient on my list I cannot bring before you for she lies in another hospital (Howard). But I thought her case so unusual and instructive that a brief report of it might interest and perhaps instruct you. She is a young girl of twenty years. She enjoyed good health until two weeks before I saw her, when, on the last day of a menstrual period, she was seized with violent vomiting and purging, with profound prostration and intense pain in the lower abdomen. After four or five days the vomiting and purging ceased, but the pain and general weakness continued. When she entered the dispensary-room of the Howard Hospital, she walked slowly, somewhat bent over, and taking short steps. Her appearance was very bad, and suggested a serious illness. The pulse was rapid, and the temperature over 100°. On abdominal examination, a mass was felt filling the lower

abdomen from the symphysis midway to the umbilicus and reaching laterally to the iliac bones. I suspected pregnancy, but the girl denied it; there were no mammary symptoms, no discoloration of the vaginal mucous membrane, the hymen was found intact, and the cervix was not in the least softened. This was all that could be learned from a vaginal examination, for the cervix stood out like a nipple from a dense mass of exudate in all directions. The abdomen was opened two days later. The mass was composed of agglutinated intestines and exudate. Scattered through it were four or five collections of very foul-smelling pus. The largest was not far below the umbilicus and just beneath the omentum. The others were deeper, but I could find no connection between them and the uterine adnexa, which were involved in the general adhesions, but were not distended or otherwise diseased. The pus was evacuated, the abdominal cavity irrigated and drained. For a day or two I thought the girl would die, but she is now well on in her second week, and I think out of danger. I am at a loss to explain these abscesses, unless we accept the explanation offered by the patient herself: She was obliged in her daily work to lean constantly against the edge of a high table, and often complained of abdominal soreness in consequence. To this she attributed her illness, and it is possible that she may have so bruised the intestinal walls as to have caused perhaps ulceration at spots, or at any rate such a reduction of vitality as to permit the " Durchwanderung " of pyogenic microörganisms. There may also have been a tuberculous element in the case, but this I could not demonstrate.